		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034256

Facility Name: MASON CITY AREA NURSING HOME

Address: 520 N. PRICE AVENUE (Number) Mason City (City) 62664 (Zip Code)

County: Mason

Telephone Number: (217) 482-5022 **Fax #** ( )

IDPA ID Number: 371168043001

Date of Initial License for Current Owners: 02/16/89

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Joyce Conrady
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Craig L. Ater, Senior V.P. and Chief Financial Officer
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,078	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,078	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,346	5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,707	6,713	1,759	18,179	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	6,392	0	6,392	12
13	DD 16 OR LESS					13
14	TOTALS	9,707	13,105	1,759	24,571	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 02/16/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,759

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	200,813	10,411		211,224		211,224		211,224			1
2	Food Purchase		129,856		129,856		129,856		129,856			2
3	Housekeeping	60,030	15,976		76,006		76,006		76,006			3
4	Laundry	46,227	6,075		52,302		52,302		52,302			4
5	Heat and Other Utilities			62,891	62,891		62,891		62,891			5
6	Maintenance	57,412	23,442	30,509	111,363		111,363		111,363			6
7	Other (specify):*											7
8	**TOTAL General Services**	364,482	185,760	93,400	643,642		643,642		643,642			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,079,559	72,308	2,222	1,154,089		1,154,089		1,154,089			10
10a	Therapy		68,011	121,861	189,872	(73,700)	116,172		116,172			10a
11	Activities	48,075	2,708		50,783		50,783		50,783			11
12	Social Services	17,179	30	1,568	18,777		18,777		18,777			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,144,813	143,057	134,651	1,422,521	(73,700)	1,348,821		1,348,821			16
	C. General Administration											
17	Administrative	62,088			62,088		62,088		62,088			17
18	Directors Fees											18
19	Professional Services			106,026	106,026		106,026	(1,026)	105,000			19
20	Dues, Fees, Subscriptions & Promotions			50,986	50,986	(36,234)	14,752	(6,424)	8,328			20
21	Clerical & General Office Expenses	149,472	10,293	16,786	176,551		176,551		176,551			21
22	Employee Benefits & Payroll Taxes			357,298	357,298		357,298		357,298			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			4,430	4,430		4,430	(2,431)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			104,013	104,013		104,013		104,013			26
27	Other (specify):*											27
28	**TOTAL General Administration**	211,560	10,293	641,538	863,391	(36,234)	827,157	(9,881)	817,276			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,720,855	339,110	869,589	2,929,554	(109,934)	2,819,620	(9,881)	2,809,739			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MASON CITY AREA NURSING HOME #0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			112,999	112,999		112,999	(6,360)	106,639			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,351	4,351		4,351	(4,351)				32
33	Real Estate Taxes			2,314	2,314		2,314	(2,314)				33
34	Rent-Facility & Grounds							(3,834)	(3,834)			34
35	Rent-Equipment & Vehicles			6,335	6,335		6,335	(1,233)	5,102			35
36	Other (specify):*											36
37	**TOTAL Ownership**			125,999	125,999		125,999	(18,092)	107,907			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					73,700	73,700		73,700			39
40	Barber and Beauty Shops		562	13,262	13,824		13,824		13,824			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					36,234	36,234		36,234			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		562	13,262	13,824	109,934	123,758		123,758			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,720,855	339,672	1,008,850	3,069,377		3,069,377	(27,973)	3,041,404			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,233)	35		5
6	Rented Facility Space	(3,834)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,360)	30		9
10	Interest and Other Investment Income	(4,351)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	(2,314)	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(40)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,431)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,026)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,384)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,973)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (27,973)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MASON CITY AREA NURSING HOME

ID# 0034256

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		$			1
2					2
3					3
4					4
5			(1,233)	35	5
6			(3,834)	34	6
7					7
8					8
9			(6,360)	30	9
10				32	10
11					11
12					12
13			0	2	13
14				32	14
15				33	15
16				24	16
17			(40)	20	17
18					18
19				24	19
20			0	27	20
21					21
22			(1,026)	19	22
23					23
24			0	27	24
25			(6,384)	20	25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	**Total**		(18,877)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,026)	0	0	0	0	0	0	0	0	0	0	(1,026)	19
20	Fees, Subscriptions & Promotions	(6,424)	0	0	0	0	0	0	0	0	0	0	(6,424)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,431)	0	0	0	0	0	0	0	0	0	0	(2,431)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,881)	0	0	0	0	0	0	0	0	0	0	(9,881)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,881)	0	0	0	0	0	0	0	0	0	0	(9,881)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,351)	0	0	0	0	0	0	0	0	0	0	(4,351)	32
33	Real Estate Taxes	(2,314)	0	0	0	0	0	0	0	0	0	0	(2,314)	33
34	Rent-Facility & Grounds	(3,834)	0	0	0	0	0	0	0	0	0	0	(3,834)	34
35	Rent-Equipment & Vehicles	(1,233)	0	0	0	0	0	0	0	0	0	0	(1,233)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,092)	0	0	0	0	0	0	0	0	0	0	(18,092)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,973)	0	0	0	0	0	0	0	0	0	0	(27,973)	45

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a				100.00%			2
3	V								3
4	V	19				100.00%			4
5	V								5
6	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	100.00%			6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$	Heritage Enterprises, Inc.	100.00%	$	$ #VALUE!	15
16	V								#VALUE!	16
17	V								#VALUE!	17
18	V								#VALUE!	18
19	V								#VALUE!	19
20	V								#VALUE!	20
21	V								#VALUE!	21
22	V								#VALUE!	22
23	V								#VALUE!	23
24	V								#VALUE!	24
25	V								#VALUE!	25
26	V								#VALUE!	26
27	V								#VALUE!	27
28	V								#VALUE!	28
29	V								#VALUE!	29
30	V								#VALUE!	30
31	V								#VALUE!	31
32	V								#VALUE!	32
33	V								#VALUE!	33
34	V								#VALUE!	34
35	V								#VALUE!	35
36	V								#VALUE!	36
37	V								#VALUE!	37
38	V								#VALUE!	38
39	Total				$			$ 0	$ * #VALUE!	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	Heritage Enterprises, Inc.		$	$ #VALUE!	15
16	V							#VALUE!	16
17	V							#VALUE!	17
18	V							#VALUE!	18
19	V							#VALUE!	19
20	V							#VALUE!	20
21	V							#VALUE!	21
22	V							#VALUE!	22
23	V							#VALUE!	23
24	V							#VALUE!	24
25	V							#VALUE!	25
26	V							#VALUE!	26
27	V							#VALUE!	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * #VALUE!	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10	**Interest Income**											10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MASON CITY AREA NURSING HOME COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0034256

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,729 B. General Construction Type: Exterior Brick/Wood Frame wood Number of Stories

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	land			$ 36,000	1
2					2
3	TOTALS			$ 36,000	3

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97				$ 2,605,181	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1990 Improvements			1990	7,990						9
10	1991 Improvements			1991	16,512						10
11	1992 Improvements			1992	22,678						11
12	1993 Improvements			1993							12
13	1994 Improvements			1994	24,788						13
14	1995 Improvements			1995	17,777						14
15											15
16	Water Heater			1997	4,800						16
17	Asphalt Sealer			1997	5,395						17
18	Entrance & Walkway			1997	1,700						18
19	Landscaping			1997	6,770						19
20											20
21	Kitch Central A/C			1996	15,800						21
22	Central A/C Administrative Offices			1996	2,500						22
23	Landscapping			1996	2,710						23
24	Automatic Door Closers			1996	3,732						24
25											25
26	Life Safety Alarm			1998	992						26
27	Sound System Cafeteria			1998	1,442						27
28	Security System			1998	10,742						28
29											29
30	Parking Lot Paving			1999	4,190						30
31	Petroleum tank			1999	12,500						31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					85,568		85,568		1,173,358	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Firewalls---ceilling	2000	$ 10,800	$		$	$	$	37
38	Facility Remodel--Materials (Carpeting)	2000	22,660						38
39									39
40	Wallpaper	2001	5,552						40
41	Carpet Installation	2001	4,141						41
42	Woodwork Refinishing	2001	418						42
43	Water Heater	2001	6,125						43
44	Facility Remodel--Labor	2001	1,520						44
45	Parking Lot	2001	9,375						45
46	Living room Remodel	2001	415						46
47	Facility Remodel--Materials	2001	23,795						47
48	Ceramic Tile Shower	2001	698						48
49	Hot Water Pump	2001	2,586						49
50	Carpeting and Installation	2001	2,208						50
51	Wander Guard	2001	1,270						51
52	Light Fixtures and Door	2001	2,777						52
53	Flooring	2001	1,311						53
54									54
55	Painting	2002	1,500						55
56	Remodel & Update Nurses Station	2002	13,224						56
57	Decorative consulting	2002	3,982						57
58	Living room Remodel	2002	493						58
59									59
60	Remodel & Update Nurses Station	2003	14,461						60
61	Roof	2003	10,085						61
62	Window Treatments	2003	1,484						62
63	Water Heater	2003	6,355						63
64	Heater/Air Conditioning Unit	2003	1,095						64
65	Rim Device	2003	1,290						65
66	Drywall	2003	2,817						66
67	Flooring								67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,920,636	$ 85,568		$ 85,568	$	$ 1,173,358	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,920,636	$ 85,568		$ 85,568	$	$ 1,173,358	1
2									2
3	Wall Coverings	2004	1,392						3
4	Walkin Cooler/Freezer	2004	21,245						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,943,273	$ 85,568		$ 85,568	$	$ 1,173,358	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 495,986	$ 21,071	$ 21,071	$		$ 432,232	71
72	Current Year Purchases	13,979						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 509,965	$ 21,071	$ 21,071	$		$ 432,232	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,489,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,639	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,639	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,605,590	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Assets	$ 130,392	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 130,392	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,102 Description: pager, computer equipment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 39,712	$		$ 39,712	1
2	Licensed Speech and Language Development Therapist		hrs			6,983			6,983	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			68,707	770		69,477	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				67,241		67,241	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					6,459			6,459	13
14	TOTAL			$		$ 121,861	$ 68,011		$ 189,872	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 351,485	$	1
2	Cash-Patient Deposits	6,231		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	358,762		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,698		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 768,176	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	71,000		13
14	Buildings, at Historical Cost	3,038,664		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	509,966		16
17	Accumulated Depreciation (book methods)	(1,616,155)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,003,475	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,771,651	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,094	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,231		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,379		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,767		31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,425		32
33	Accrued Interest Payable	94		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 229,990	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	56,716		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 56,716	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 286,706	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,484,945	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,771,651	$	48

***(See instructions.)**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,485,627	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,485,627	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(682)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (682)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,484,945	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,097,518	1
2	Discounts and Allowances for all Levels	(422,388)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,675,130	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	239,490	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 239,490	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,191	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,834	16
17	Sale of Drugs	118,979	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,902	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 141,906	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,869	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,869	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,059,395	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	643,642	31
32	Health Care	1,422,521	32
33	General Administration	863,391	33
	B. Capital Expense		
34	Ownership	125,999	34
	C. Ancillary Expense		
35	Special Cost Centers	13,824	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		(9,300)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,060,077	40
41	**Income before Income Taxes (line 30 minus line 40)****	(682)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (682)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,868	2,080	$ 55,730	$ 26.79	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,911	8,443	169,037	20.02	3
4	Licensed Practical Nurses	18,390	19,912	319,977	16.07	4
5	Nurse Aides & Orderlies	46,172	50,717	464,641	9.16	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,521	6,027	70,174	11.64	8
9	Activity Director					9
10	Activity Assistants	5,613	5,828	48,075	8.25	10
11	Social Service Workers	1,518	1,566	17,179	10.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,136	25,017	200,813	8.03	15
16	Dishwashers					16
17	Maintenance Workers	5,005	5,763	57,412	9.96	17
18	Housekeepers	7,778	8,278	60,030	7.25	18
19	Laundry	5,573	5,906	46,227	7.83	19
20	Administrator	2,000	2,080	62,088	29.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,239	10,102	149,472	14.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,724	151,719	$ 1,720,855 *	$ 11.34	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		1,182		37
38	Nurse Consultant				38
39	Pharmacist Consultant		50		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		240		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,472		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joyce Conrady	Administrator		$ 62,088
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,088

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management	$ 97,800
Abbott & Co	Audit	7,200
		0
		0
Legal fees (Adj to Zero)		1,026
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 106,026

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,797
Unemployment Compensation Insurance	5,458
FICA Taxes	131,645
Employee Health Insurance	149,892
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	31,506
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 357,298

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	920
Health Care Worker Background Check	
(Indicate # of checks performed)	371
Central Office Allocation	
Promotional Advertising	1,175
Public Relations	5,209
Dues and Subscriptions	6,142
License and Fees	935
Less: Public Relations Expense	(5,209)
Non-allowable advertising	(40)
Yellow page advertising	(1,175)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,328

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,594
	198
Seminar Expense	1,638
	(2,431)
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MASON CITY AREA NURSING HOME **#** 0034256 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **36,234**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **9,394**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Abbott & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **Not available at this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number		Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/ Line #	Sch 5 pg 3/ Col #	Sch 6 pg 5 Line #	Adjustment Amount				
1009		PETTY CASH	351,485							1,009	1,009 PETTY CA	351,485
1010		CASH IN BANK								1,100	1,100 ACCTS RE	358,762
1040		CASH IN BANK-PAYROLL								1,101	1,101 ALLOW. FOR UNCOLLECTIBLES	
1100		ACCOUNTS RECEIVABLE	358,762							1,110	1,110 ACCTS RECEIV-M/C	
1110		MEDICARE RECEIVABLES								1,125	1,125 ACCTS RECEIV-IPA	
1125		IPA INCOME RECEIVABLE								1,135	1,135 ACCTS RECEIV-IC	
1130		MEDICARE COST REPORT								1,140	1,140 UNAPPLIED CASH RECEIPTS	
1135		ACCOUNTS RECEIVABLE-IC								1,145	1,145 A/R SUSPENSE-REFUNDS	
1140		UNAPPLIED CASH RECEIPTS								1,200	1,200 PREPAID I	51,698
1145		A/R SUSPENSE-REFUNDS								1,220	1,220 OTHER PREPAID EXPENSES	
1190		ACCRUED INTEREST REC								1,300	1,300 DIETARY INVENTORY	
1200		PREPAID INSURANCE	51,698							1,310	1,310 SUPPLIES INVENTORY	
1220		OTHER PREPAID EXPENSES								1,320	1,320 LINEN INVENTORY	
1300		FOOD INVENTORY								1,409	1,409 LAND	71,000
1310		SUPPLIES INVENTORY								1,450	1,450 FURNITUR	509,966
1409		LAND	71,000							1,460		-432,232
1450		FURNITURE & EQUIPMENT	509,966							1,475	1,475 CODE ALE	3,038,664
1460		ACCUM DEPR-FURN & EQUIP	-432,232							1,490	1,490 ACCUM D	-1,183,923
1475		BUILDING & IMPROVEMENTS	3,038,664							1,530	1,530 RESIDENT	6,231
1490		ACCUM DEPR-BUILDING	-1,183,923							1,550	1,550 LOAN FEE	0
1530		RESIDENT FUNDS	6,231							1,551	1,551 LOAN FEES ADDED	
1550		LOAN FEES	0							1,850	1,850 INTERCOM	0
1560		REAL ESTATE TAX ESCROW								2,010	2,010 ACCOUNT	-73,094
1575		REIMBURSABLE PURCHASES								2,100	2,095 BONUSES PAYABLE	
1850		INTRACOMPANY	0							2,100	2,100 ACCRUED	-32,296
2010		ACCOUNTS PAYABLE	-73,094							2,100	2,100 PR CLEARING-BENEFITS	
2095		BONUSES PAYABLE								2,100	2,100 PR CLEARING-LABOR	
2100		ACCRUED PAYROLL	-32,296							2,110	2,110 ACCRUED	-99,083
2110		ACCRUED VACATION PAY	-99,083							2,120	2,120 U.C. TAXES PAYABLE	
2120		UC TAXES PAYABLE								2,125	2,125 FICA TAX	-16,767
2125		FICA TAX PAYABLE	-16,767	-16,767						2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130		FIT PAYABLE								2,140	2,140 STATE W/H TAX PAYABLE	
2140		STATE W/H PAYABLE		0						2,152	2,152 WORKERS COMP ACCRUAL	
2145		EARNED INCOME CREDIT								2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2150		UC FED CREDIT REDUCTION								2,230	2,230 PAYROLL SAVINGS	
2230		PAYROLL SAVINGS								2,235	2,240 UNITED FUND	
2235		IRA W/HOLDINGS								2,240	2,246 GROUP INSURANCE - CAFETERIA	
2240		UNITED WAY								2,246	2,250 401K W/H	
2245		GROUP INSURANCE PAYABLE								2,250		
2246		GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260 WAGE GARNISHMENT	
2260		WAGE GARNISHMENTS								2,300	2,300 ACCRUED	-94
2280		MISC PAYROLL DEDUCTIONS								2,320	2,320 IPA PAYM	0
2300		ACCRUED INTEREST PAYABLE	-94							2,350	2,350 REAL EST.	-2,425
2310		SALES TAX PAYABLE								2,385		
2320		IPA PAYMENTS PAYABLE	0							2,400	2,400 CURRENT PORTION OF LT DEBT	
2350		REAL ESTATE TAX PAYABLE	-2,425							2,512	2,512 DUE TO RI	-6,231
2385		ACTIVITY FUND	0							2,600	2,600 LASALLE	-56,716
2390		SECURITY DEPOSITS								2,600		
2391		VOLUNTEER FUND								2,625	2,625 LASALLE CONSTR. LOAN #2	
2393		HEART FUND/BAZAAR								2,625		
2395		DEFERRED INC EMP & MEM								2,695	2,695 CURRENT PORTION OF LT DEBT	
2400		CURRENT PORTION LT DEBT								2,720	2,720 RETAINED	-2,485,627
2460		INCOME TAXES PAYABLE									net income	682
2512		DUE TO RESIDENTS	-6,231									
2600		MORTGAGE PAYABLE	-56,716									
2650		EQUIPMENT LOAN PAYABLE									balance	0
2695		CURRENT PORTION LT DEBT										
2696		DEFERRED INCOME TAXES										
2710		COMMON STOCK										
2720		RETAINED EARNINGS	-2,485,627									
2970		PROFIT/LOSS FOR PERIOD	682									
3007.1		PATIENT DAYS-PRIVATE	17,513							3,007	3,007 PATIENT I	17,513
3007.2		PATIENT DAYS-IPA	9,707							3,007	3,007 PATIENT I	9,707
3007.3		PATIENT DAYS-MEDICARE	1,759							3,007	3,007 PATIENT I	1,759
3007.4		PATIENT DAYS-CONVERSION								3,007		0
3007.5		PATIENT DAYS-LICENSED								3,007		
3007.6		PATIENT DAYS-TOTAL								3,007		
3010	1	BASIC CHARGE-PRIVATE & VA	-1,511,740		0	0	0	0		3,007		
3015	1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3,010	3,010 BASIC CH.	(1,511,740)
3020	1	BASIC CHARGE-IPA	-800,553		0	0	0	0		3,020	3,020 BASIC CH.	(800,553)
3030	1	BASIC CHARGE-MEDICARE	-484,491		0	0	0	0		3,030	3,030 BASIC CH.	(484,491)
3035	4	DAY CARE/HOME CARE			0	0	0	0		3,040	3,040 LIGHT NU	(22,233)
3040	1	LIGHT NURSING CARE	-96,109		0	0	0	0		3,050	3,050 MEDIUM N	(54,124)
3050	1	MEDIUM NURSING CARE			0	0	0	0		3,060	3,060 HEAVY NU	(18,912)
3060	1	HEAVY NURSING CARE			0	0	0	0		3,061	3,061 SKILLED N	(840)
3061	1	SKILLED NURSING CARE								3,080	3,080 NURSING	(68,648)
3080	1	NURSING SUPPLIES-PRIVATE	-204,625		0	0	0	0		3,081	3,081 NURSING	(95,396)
3081	1	NURSING SUPPLIES-IPA			0	0	0	0		3,082	3,082 NURSING	(22,651)
3082	1	NURSING SUPPLIES MED PT A			0	0	0	0		3,083	3,083 NURSING	(17,930)
3083	1	NURSING SUPPLIES MED PT B								3,100	3,100 DRUGS-MI	(118,979)
3100	17	DRUGS	-118,979		0	0	0	0		3,101		
3101	17	DRUGS-OTHER								3,110	3,110 PHYSICAL	(920)
3110	6	PT-PRIVATE	-239,490		0	0	0	0		3,111		
3111	6	PT-IPA			0	0	0	0		3,112	3,112 PHYSICAL	(97,000)
3112	6	PT-MEDICARE PART A			0	0	0	0		3,113	3,113 PHYSICAL	(39,660)
3113	6	PT-MEDICARE PART B			0	0	0	0		3,140	3,140 LABORAT	(11,851)
3130	1	PUBLIC AID ASSESSMENT INC								3,150	3,150 ST/OT THE	(3,480)
3140	19	LABORATORY INCOME			0	0	0	0		3,151		
3150	6	SPEECH/OT-PRIVATE			0	0	0	0		3,152	3,152 ST/OT THE	(52,240)
3151	6	SPEECH/OT-IPA			0	0	0	0		3,153	3,153 ST/OT THE	(26,120)
3152	6	SPEECH/OT-MED PART A			0	0	0	0		3,160	3,160 X-RAY SE	(8,219)
3153	6	SPEECH/OT MED PART B								3,410	3,410 IPA DISCO	111,609
3410	2	IPA DISCOUNTS	422,388		0	0	0	0		3,411	3,411 MEDICARI	8,184
3411	2	MEDICAID PART B DISCOUNT			0	0	0	0		3,420	3,420 MEDICARI	302,595
3420	2	MEDICARE DISCOUNTS			0	0	0	0		3,500		
3440	36	ASSESSMENT TAX EXPENSE			42	3	0	0		3,520	3,520 RENT INC	(3,834)
3520	16	RENT INCOME	-3,834		6	0	6	-3,834		3,530	3,530 BEAUTY S	(16,191)
3530	13	BEAUTY SHOP	-16,191		0	0	0	0		3,560		
3560	12	ACTIVITY FUND INCOME	0		0	0	0	0		3,570		
3570	12	VENDING INCOME/EXPENSE	0		0	0	0	0		3,590		
3580	12	MANAGEMENT FEES			0	0	0	0		3,595	3,580 PERSONAL	78
3590	1	EQUIPMENT RENTAL	0		0	0	0	0		3,600	3,600 MISC INC	(2,980)
3595	21	RESIDENT TRANSPORTATION	78		0	0	0	0		4,110	4,110 G&A WAG	139,212
3600	21	MISC INCOME	-2,980		0	0	0	0		4,111	4,111 ADMINIST	62,088
4110		GENERAL & ADMINIST WAGES	139,212	149,472	21	1	17	0		4,115	4,115 G&A PTO	10,260
4111		ADMINISTRATOR WAGES	62,088	62,088	17	1	0	0		4,120	4,120 EMPLOYE	31,540
4115		VACATION & SICK - G&A	10,260		21	1	0	0		4,125		
4120 4475		EMPLOYEE BENEFITS	31,506	357,298	22	3	0	0		4,130		
4125		EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0		4,135		
4130		EMPLOYEE SCHOLORSHIP WA	0		21	1	0	0		4,250	4,250 OFFICE SU	6,662
4135		EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0		4,255	4,255 POSTAGE	3,167
4220		DIRECTORS FEES			18	3	0	0		4,260	4,260 TELEPHON	16,786
4250 4255		OFFICE SUPPLIES	10,293	10,293	21	2	0	0		4,275	4,275 TRAINING	1,999
4260		TELEPHONE	16,786	16,786	21	3	0	0		4,276		
4275		TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0 **		4,280	4,280 GENERAL	2,594
4280		GENERAL TRAVEL	2,594	4,430	24	3	16	0		4,281	4,281 MEAL EXP	198
4281		MEAL EXPENSE FOR TRAVEL	198		24	3	19	0		4,285	4,285 EDUCATIO	1,318
4285		EDUCATION & SEMINAR	1,638		24	3	19	-2,431 ***		4,289	4,289 MEETINGS	320
4290		HELP WANTED ADVERTISING	920	50,986	20	3	0	0	-36,234	4,290	4,290 HELP WAN	920
4291		PROMOTIONAL ADVERTISING	1,175		20	3	25	-1,175		4,291	4,291 PROMOTIO	1,175
4292		PUBLIC RELATIONS	5,209		20	3	25	-5,209		4,292	4,292 PUBLIC RI	5,209
4300		LICENSES & FEES	37,169		20	3	17	0		4,300	4,300 LICENSE &	37,169
4310		DUES & SUBSCRIPTIONS	6,142		20	3	17	-40		4,310	4,310 DUES & SU	6,142
4320		CONTRIBUTIONS	0		27	3	20	0		4,320		
4350		PROFESSIONAL FEES	5,526	106,026	19	3	22	-1,026		4,350	4,350 PROFESSI	5,526
4355		MEDICAL DIRECTOR	9,000	9,000	9	3	0	0		4,355	4,355 MEDICAL	9,000
4360		UTILIZATION REVIEW			10	3	0	0		4,362	4,361 OTHER PH	1,182
4361		OTHER PHYSICIAN FEES			39	3	0	0		4,363	4,363 PHARMAC	50
4362		MEDICAL RECORDS CONSULT	1,182		10	3	0	0		4,364	4,364 SOCIAL SE	240
4363		PHARMACIST FEES	50		10	3	0	0		4,370	4,370 TV RENTA	2,164
4364		SOC SERV/ACT CONSULT	240	240	12	3	0	0		4,383	4,383 BACKGRO	371
4370		TV RENTAL	2,164		35	3	5	-1,233		4,390		
4380		INCOME TAXES		0	27	3	26	0		4,400	4,400 PAYROLL	130,658
4383		BACKGROUND CHECKS	371		20	3	26	0		4,401	4,401 PAYROLL	6,445
4400		PAYROLL TAXES	130,658		22	3	0	0		4,410	4,410 GROUP IN	149,892
4401		PAYROLL TAXES ADMINIST	6,445		22	3	0	0		4,420	4,420 LIABILITY	104,013
4410		GROUP INSURANCE	149,892		22	3	0	0		4,430	4,430 WORKMA	38,797
4420		LIABILITY INSURANCE	104,013	104,013	26	3	0	0		4,435		
4425		INSURANCE-OWNERS			22	3	21	0		4,436		
4430		WORKMENS COMP INSURANCI	38,797		22	3	0	0		4,450	4,450 MANAGEM	100,500
4450		CENTRAL OFFICE FEES	100,500		19	3	34	0		4,460		
4460		BAD DEBTS	0		27	3	24	0		4,461		
4470		LOST ITEMS-RESIDENTS	0		27	3	0			4,470		
4490		MISCELLANEOUS	0		27	3	0	0		4,475	4,475 UNIFORM	(34)
4510		REAL ESTATE TAXES	2,314	2,314	33	3	0	-2,314		4,486	4,486 SERVICE C	8,592
4600		LEASED EQUIPMENT	4,171	6,335	35	3	16	0		4,490	4,490 MISC EXP	146
5110		MAINTENANCE SALARIES	50,735	57,412	6	1	0	0		4,496	4,496 MISC. M.I.	464
5120		MAINTENANCE SICK & VAC	6,677		6	1	0	0		4,510	4,510 REAL EST.	2,314
5130		ELECTRIC	37,896	62,891	5	3	0	0		4,600	4,600 LEASED E	4,171
5131		NATURAL GAS	16,491		5	3	0	0		5,110	5,110 MAINTENA	50,735
5132		HEATING & DEISEL OIL			5	3	0	0		5,120	5,120 MAINTENA	6,677
5133		WATER & SEWER	8,504		5	3	0	0		5,130	5,130 ELECTRIC	37,896
5134		TRASH COLLECTION	2,012	30,509	6	3	0	0		5,131	5,131 NATURAL	16,491
5140		PROPERTY PLANT REPLACEMN	2,574	23,442	6	2	0	0		5,133	5,133 WATER &	8,504
5160		GENERAL REPAIR & MAINT	20,868		6	2	0	0		5,134	5,134 TRASH CC	2,012
5165		MAINTENANCE CONTRACTS	28,497		6	3	0	0		5,140	5,140 PROP/PLA	2,574
5210		DIETARY WAGES	189,067	200,813	1	1	0	0		5,160	5,160 GENERAL	20,868
5220		DIETARY SICK & VAC	11,746		1	1	0	0		5,165	5,165 MAINTENA	19,905
5240		SALES TAX			2	3	13	0		5,210	5,210 DIETARY	189,067
5248		FOOD PURCHASES	139,250	129,856	2	2	0	0		5,220	5,220 DIETARY	11,746
5250		SUPPLIES-DISHWASHING	2,813	10,411	1	2	0	0		5,248	5,248 FOOD PUR	139,104
5260		DIETARY REPLACEMENT	1,790		1	2	0	0		5,250	5,250 SUPPLIES	2,813
5270		KITCHEN SUPPLIES-PAPER	5,808		1	2	0	0		5,260	5,260 REPLACEM	1,790
5295		MEAL CREDIT	-9,394		2	2	0	0		5,270	5,270 KITCHEN	5,808
5310		LAUNDRY WAGES	43,660	46,227	4	1	0	0		5,295	5,295 MEAL INC	(9,394)
5340		LAUNDRY SICK & VAC	2,567		4	1	0	0		5,310	5,310 LAUNDRY	43,660
5370		LAUNDRY REPLACEMENT	-1,160	6,075	4	2	0	0		5,340	5,340 LAUNDRY	2,567
5380		LAUNDRY REIMBURSEMENT			4	3	0	0		5,370	5,370 REPLACEM	(1,160)
5390		LAUNDRY SUPPLIES	7,235		4	2	0	0		5,380		
5410		HOUSEKEEPING WAGES	55,045	60,030	3	1	0	0		5,390	5,390 SUPPLIES	7,235
5440		HOUSEKEEPING SICK & VAC	4,985		3	1	0	0		5,410	5,410 HOUSEKE	55,045
5480		HOUSEKEEPING SUPPLIES	5,529	15,976	3	2	0	0		5,440	5,440 HOUSEKE	4,985
5490		HOUSEKEEPING SUPPLIES-PPR	10,447		3	2	0	0		5,480	5,480 SUPPLIES-	5,529
6010		RN WAGES-MEDICARE		1,079,559	10	1	0	0		5,490	5,490 SUPPLIES-	10,447
6020		RN WAGES-NON MEDICARE	155,200		10	1	0	0		6,020	6,020 RN WAGE	155,200
6030		DON WAGES	55,730		10	1	0	0		6,030	6,030 DON WAG	55,730
6035		ADON	0		10	1	0	0		6,035		
6040		RN SICK & VACATION	13,837		10	1	0	0		6,040	6,040 RN PTO &	13,837
6110		LPN WAGES-MEDICARE			10	1	0	0		6,120	6,120 LPN WAGI	301,599
6120		LPN WAGES-NON MEDICARE	301,599		10	1	0	0		6,140	6,140 LPN PTO &	18,378
6130		LPN WAGES OTHER			10	1	0	0		6,220	6,220 AIDES WA	433,022
6140		LPN SICK & VACATION	18,378		10	1	0	0		6,240	6,240 AIDES PTO	31,619
6210		AIDE WAGES-MEDICARE			10	1	0	0		6,245		
6220		AIDE WAGES-NON MEDICARE	433,022		10	1	0	0		6,246		
6230		WARD CLERKS			10	1	0	0		6,247		
6240		AIDE VACATION & SICK	31,619		10	1	0	0		6,250		
6245		CONTRACT NURSES-RN	0		10	3	0	0		6,255		
6246		CONTRACT NURSES-LPN	0		10	3	0	0		6,260		
6247		CONTRACT NURSES-AIDES	0		10	3	0	0		6,270	6,270 REHAB W.	65,373
6250		NURSE AIDE TRAINING WAGES	0	0	13	1	0	0		6,275	6,275 REHAB PT	4,801
6255		NURSE AID TRAINING EXP	0	0	13	2	0	0		6,290	6,290 NURSING	55,666
6260		NURSE AIDE TRAINING REIMB	0		0	0	0	0		6,295	6,295 NURSING	15,682
6270		REHAB WAGES	65,373		10	1	0	0		6,390	6,390 REPLACEM	960
6275		REHAB SICK & VAC	4,801		10	1	0	0		6,490	6,490 OTHER	990
6280		NURSING DEPT EDUCATION			23	3	0	0		7,280	7,280 DRUG PUR	57,968
6290		NURSING SUPPLIES	55,666	72,308	10	2	0	0		7,281	7,380 LABORAT	9,273
6295		NURSING SUPPLIES	15,682		10	2	0	0		7,380	7,390 X-RAY SE	6,459
6390		REPLACEMENT-NURSING	960		10	2	0	0		7,391		
6490		NURSING OTHER	990	2,222	10	3	0	0		7,393		
7280		DRUG PURCHASES	57,968	68,011	39	2	0	0 ***		7,510	7,510 ACTIVITIE	46,127
7281		DRUG PURCHASES-OTHER	9,273		39	2				7,540	7,540 ACTIVITIE	1,948
7380		LABORATORY SERVICES	6,459	121,861	39	3	0	0		7,590	7,590 ACTIVITIE	2,708
7410		HOME HEALTH SALARY			39	1	0	0		7,620	7,620 PHYSICAL	68,707
7440		HOME HEALTH SICK & VAC			39	1	0	0		7,660	7,660 P.T. SUPPL	770
7450		HOME HEALTH EXPENSES			39	3	0	0		7,710	7,710 SOCIAL SE	16,488
7510		ACTIVITES WAGES	46,127	48,075	11	1	0	0		7,720	7,720 SOCIAL SE	691
7540		ACTIVITIES SICK & VAC	1,948		11	1	0	0		7,730	7,730 SOCIAL SE	30
7590		ACTIVITIES SUPPLIES	2,708	2,708	11	2	0	0		7,740	7,740 OCCUPAT	39,712
7595		ACTIVITIES FEES	0	0	11	3	0	0		7,750	7,750 SOCIAL C	1,328
7610		PT WAGES			39	1	0	0		7,770	7,770 SPEECH T	6,983
7611		PT SICK & VACATION			39	1	0	0		7,820	7,820 BEAUTICI	13,262
7620		PT FEES	68,707		39	3	0	0 ***		7,890	7,890 BEAUTY S	562
7660		PT SUPPLIES	770		39	2	0	0		7,960		
7710		SOCIAL SERVICE WAGES	16,488	17,179	12	1	0	0		8,120	8,120 INTEREST	4,351
7720		SOCIAL SERVICE SICK & VAC	691		12	1	0	0		8,125		
7730		SOCIAL SERVICE EXPENSES	30	30	12	2	0	0		8,130	8,130 DEPRECIA	112,999
7740		OT FEE	39,712		39	3	0	0 ***		8,150		
7750		SOCIAL THERAPIST FEE	1,328	1,328	12	3	0	0		9,510	9,510 INTEREST	(2,869)
7770		SPEECH THERAPY FEE	6,983		39	3	0	0 ***		9,520	9,520 MISC NON	(9,300)
7800		BEAUTICIAN WAGES		0	40	1	0	0		9,530		
7810		BEAUTICIAN SICK & VAC			40	1	0	0				
7820		BEAUTICIAN FEES	13,262	13,262	40	3	0	0				682
7890		BEAUTY SHOP SUPPLIES	562	562	40	2	0	0				
7910		VOLUNTEER COORDINATOR			21	1	0	0				
7940		VOL COORD SICK & VAC			21	1	0	0				
7960		VOL COORD SUPPLIES	0		21	2	0	0				
8100		RENT		0	34	3	0	0				
8120		INTEREST EXPENSE	4,351	4,351	32	3	14	-4,351				
8130		DEPRECIATION	112,999	112,999	30	3	9	-6,360				
8150		LOAN FEE AMORTIZATION	0		32	3	0	0	60,773			
9510		INTEREST INCOME	-2,869		32	0	10	0				
9520		MISC NON-OPERATING INCOM	0		0	0	0	0				
9700		INCOME TAXES	-9,300		0	0	0	0				
			3,057,208	3,069,377								
				12,169								
GRAND TOTALS			682					-27,973				
			(NET INCOME)									
			0									
		FACILITY NAME:										
		FACILITY ID:	0									
		FACILITY UNITS:	89									
		BALANCE SHEET TOTAL	0									
			173,113									

	G/L	RECAP CENSUS
PP	17,513	13,105
IPA	9,707	9,707
medicare	1,759	1,759
		24,571
IPA BEDHOLDS	0	
PP BEDHOLDS	257	
PP CONVERS	4,151	